Local authority assessments

In 2022, CQC was given new responsibilities to assess how local authorities meet their duties under the Care Act (2014). In December 2023, we started an assessment programme for all 153 local authorities in England with adult social care responsibilities, to be assessed within a 2-year period.

This year, we have analysed a sample of 27 published local authority assessment reports to explore how local authorities are ensuring good quality care and support for older people, especially those who may be frail. Of our assessments:

- 1 was rated as outstanding
- 15 were rated as good
- 11 were rated as requires improvement.

Our analysis also included reports for 5 pilot assessments, 4 of which have an indicative rating of good and 1 had an indicative rating of requires improvement.

We sought to understand the role of a local authority in prevention and early intervention, and how they work to support hospital discharge and enable people to recover and live independently in the community. The importance of effective system working was evident.

The 2025 Spring Survey from the Association of Directors of Adult Social Services highlighted that many local authorities had reviewed their data and revised their systems, partly in anticipation of CQC assessment, helping to improve how they manage waiting lists. It is encouraging to see that anticipation of our regulatory activity is driving change.

Summary findings

Prevention

- Local authorities are working closely with public health to provide targeted interventions, to prevent future care needs and avoid hospital admissions.
- Assistive technology and digital solutions, occupational therapy, and support to carers are used to support older people's independence and prevent the need to use services. Digital examples include the use of falls sensors, tracking and monitoring technology, and telecare.
- Reablement was used proactively by some local authorities to support admission avoidance strategies and prevention work. Where it was applied most effectively, local authorities had been successful in reducing or almost eliminating their waiting lists for a Care Act assessment.

Discharge from hospital

- Hospital discharge focused on a discharge to assess and 'home first' approach. This ensures that people who are medically ready to leave hospital are discharged promptly – to their own residence where possible – with assessment for long-term care fully completed following a short period of recovery.
- Partnership working across integrated teams and including voluntary partners was key to aiding smooth and timely discharge. However, waiting lists and a lack of capacity in homecare caused delays. To address this, some local authorities provided bridging services.

- People with more complex needs requiring specialist care, for example people with dementia, were harder to place, more likely to experience delays or be placed out of their local area so they could get the care they needed.

Reablement

- Reablement was a key strand of hospital discharge pathways. Local authorities worked in integrated teams with health to provide free reablement support for usually 6 to 8 weeks. Care models varied – they were led by occupational therapists, in-house authority provision or private homecare providers – and this was usually supported by the Better Care Fund.
- Successful reablement supports people to return to their own homes – and effective partnership working between hospital staff and local authority social work teams is essential to achieving good reablement outcomes.
- Barriers to effective reablement included reablement capacity in some authorities, a lack of skill and capacity in private homecare services, delays and workforce shortages in occupational therapy, and the impact of Care Act assessment waiting times.

Homecare

- Local authorities had worked to increase and improve their homecare capacity with reviews and new approaches to commissioning.
- Homecare capacity and capability remains an issue. Shortages of skilled staff coupled with a lack of homecare service providers in some areas meant they struggled to address long delays and waiting lists, which affects people's health and wellbeing. This was especially the case in rural areas.
- Good homecare commissioning needs to take population diversity and intersectionality of needs into consideration.

Prevention

The government's 10-Year Health Plan for England outlines 3 shifts to make the NHS fit for the future, one of which is a focus on prevention. How local authorities prevent, reduce and delay the need for care is an element of our local authority assurance assessments.

Many local authorities that we assessed recognised the importance of prevention and maintaining a healthy population, with prevention a major theme in their strategies. Some took a preventive approach to addressing health concerns that commonly affect older people, for example by focusing on falls prevention and blood pressure monitoring.

We also saw a proactive approach to prevention by working closely with public health bodies and using public health data to provide targeted interventions, which can prevent future need and avoid hospital admissions.

For example, one local authority used data from a joint strategic needs assessment (JSNA) to understand local need and inform commissioning priorities. The JSNA had identified an ageing population with a likelihood of people living longer and developing more complex needs or frailty. Staff told us about initiatives around falls prevention that were aligned to priorities in the JSNA.

Early intervention to avoid hospital admission – as well as to prevent, reduce and delay the need for care – is a fundamental element of local authority duties. Partnership working is important in this context. We saw examples of information sharing and 'no wrong door' approaches to support and identify those most at risk of being admitted to hospital. Several local authorities had care projects that delivered these levels of support, and particularly for older people.

The most common prevention approaches included reablement services, voluntary services, assisted technology, occupational therapy and home improvements and support to unpaid carers – all intervention options that could support people in their own homes. These often used a multi-agency approach, with health and social care staff working together.

Partnership working with community and voluntary organisations is an important strand of prevention work, particularly for those with non-eligible care needs (needs that do not meet the criteria to receive care and support following a Care Act assessment). Some local authorities commissioned a variety of community and voluntary sector organisations to support this work.

Signposting to third-sector organisations is one way in which local authorities can support people with non-eligible care needs and there were some good examples of this, where funding was rooted in the identified need for the area. However, we also saw evidence of voluntary partners struggling with funding, leading to gaps in provision.

Additionally, some local authorities use reablement to support admission avoidance strategies and prevention work. We saw that where it was applied most effectively, local authorities had been successful in reducing or almost eliminating their waiting lists for a Care Act assessment.

One authority had a well-established therapy-led reablement service that was meeting the needs of the local community. This community approach avoided people unnecessarily being admitted into care homes or hospitals.

Another local authority gave an example where a person was referred from their GP following a serious injury and was put on the reablement pathway to reduce the risk of a hospital admission. Structures were in place to help prevent unnecessary admissions and promote independence.

However, this was mixed and in some assessments we found gaps in early prevention services for older people, and it was unclear what was being done to resolve these. Measuring impact and outcomes for people was a challenge for most local authorities when evaluating the effectiveness of their prevention approaches.

Hospital discharge

Our analysis showed that when a person needs to be admitted to hospital, local authorities work in partnership with the right teams to get them discharged back to their own homes or offer an appropriate alternative as quickly and safely as possible.

They did this using either a 'home first' approach or a 'discharge to assess' approach. Close collaboration between local authorities and hospital discharge teams was essential for this to be effective.

In one example from an assessment, we saw that a fully integrated hospital discharge team started working together a year ago and is achieving positive outcomes for people being discharged from hospital. The team worked closely with the other services available for people who required varying levels of support when discharged from hospital. This varied from a voluntary service providing transport and shopping, to the reablement team providing longer-term support.

The local authority's data, as well as national data, showed that the support had enabled increased numbers of people to return home and remain at home rather than requiring longer-term support such as residential care.

In another example, hospital discharge was led by the Homesafe social care teams based in each of the acute and community hospitals. The Homesafe team was made up of social workers and social work support assistants who worked closely with occupational therapists and discharge nurses, employed by the trust as part of a wider transfer of care hub.

From research we commissioned through National Voices we know that a 'home first' approach is preferred by people leaving hospital. The vast majority of older people responding to the survey told us they had been discharged home and that this was their preferred outcome. The main things that could have improved their discharge experience were better planning and communication of those plans.

In some local authority areas, hospital discharge teams were co-located – this helped with joined-up working and led to more effective communication.

We also found that partnership working across integrated teams – including voluntary partners – can aid smooth and timely discharge. The voluntary and community sector was an important partner for local authorities, especially for people with non-eligible care needs. Other important partners included physiotherapy and occupational therapy teams. We saw how they worked in a joined-up way to ensure that people were assessed and had the aids and adaptations they needed to return to their own homes.

However, there were also challenges with hospital discharge. Where our assessment reports highlighted issues, these related to:

- communication and integrated ways of working
- a disparity in assessed care needs
- homecare capacity – especially for people with more complex needs.

Our analysis showed that there are gaps in services for people with more complex care needs, which can lead to delays in access to care home beds and out-of-area placements.

In some areas virtual wards or reablement beds were used to meet more complex needs. One authority described adjusting its in-house residential services to provide long-term specialist dementia beds. Another authority showcased its use of contingency planning to support those most in need:

In this assessment, staff shared an example of contingency planning, where they worked with care home managers to assess people in hospital and develop rehabilitation, with the view that if risks became unmanageable after discharge home, they could move directly into the care home rather than return to the hospital. Throughout the home access visit, the rehabilitation bed remained open and available for the person to return to, if risks became too high to manage at home. *Assessment example*

Local authorities told us how a lack of capacity in homecare directly affected hospital discharges.

Some local authorities had developed a bridging service to decrease this pressure on homecare, and one local authority told us how it had worked closely with homecare providers to clarify expectation around response times and delivery, as well as offering support to overcome geographical and workforce challenges. This helped to improve capacity and flow within the system.

Reablement

Looking at local authority assessment reports, we found that reablement is an important element of hospital discharge pathways. Successful reablement services for people supports people to return to their own homes with a short-term care package in place, delaying or removing the need for permanent long-term care. Services aimed to be strengths-based and person-centred. Local authorities worked in integrated teams to provide free reablement support, usually for 6 to 8 weeks.

A homecare reablement short-term service called Home First worked used 'strength-based' practice to promote people's independence by focusing on their own qualities and resources. Senior staff told us 80% of people did not require ongoing care following this service.

Reablement services work well when there are strong partnership working networks between hospital staff and local authority social work teams. For example, there is often a specific team within the local authority that supports this work, and they maintain effective links to occupational therapy teams and third-sector organisations.

These teams ensure that people have the aids, adaptions and community support to help them stay independent in the community for longer. We saw good examples of where this support had worked well for people, but in some areas there were long waiting lists for occupational therapy assessments and subsequent aids and adaptations. This can stall people's recovery.

We also found that effective partnership working between hospital staff and local authority social work teams is essential to achieving good reablement outcomes.

Local authorities made use of the Better Care Fund (BCF) for a variety of initiatives with a core purpose to reduce admissions to hospital, improve hospital discharge and provide more integrated services. Coupled with knowledge of hospital admission data, local authorities were able to use the BCF to adapt their reablement to meet their needs and areas of focus.

Some local authorities sought to build capacity and enhance their reablement services in partnership with private homecare providers. Sometimes, they met with capacity challenges in the private sector.

More generally, local authorities sought to work with reablement providers and the NHS through investing in training to upskill staff when caring and providing support for older people with complex needs. Upskilling staff helps the delivery of good quality care - and the greater understanding of specific needs can also help providers to reduce admissions to hospital and improve discharge from hospital.

We found that some local authorities face barriers to effective reablement. These include reablement capacity in some authorities, a lack of skill and capacity in private homecare services, delays and workforce shortages in occupational therapy and the impact of Care Act assessment waiting times.

Despite examples of effective and efficient reablement services, some local authorities had challenges with these services, as they were not yielding the positive results expected in terms of hospital discharge and reducing and delaying care needs. Workforce issues, such as staff shortages and recruitment, were the most frequently highlighted challenge for reablement services.

Homecare

We found that local authorities have worked to increase and improve their homecare capacity. Inspection reports noted how new approaches and reviews of homecare commissioning had led to improvements.

Examples included moves to a more neighbourhood or zone-based method of commissioning. This allowed for a more consistent staffing team, less travel time between calls and, for one authority, we heard this had meant they were able to increase pay for care staff.

Despite this work, homecare capacity remains an issue. Staff shortages, coupled with a lack of homecare agencies in some areas, means some local authorities struggle to address long homecare delays and waiting lists. This has an impact on people's health and wellbeing.

Staff skill levels in the homecare workforce also pose challenges to reablement and promoting people's independence. This is particularly the case in rural areas. Focus groups we ran in April 2025 with experts by experience underlined this point where we heard about the impact that living in rural areas can have on people's choice of homecare provider. One participant said:

"If you were in a rural area and you're lucky enough to have an agency who really is good then that's great. But if you have an agency that is poor very often, there is no other care facility and therefore you either have poor care or no care."

Local authorities are creating strategies to tackle this problem. Some local authorities have embraced using assistive technology to delay the need for homecare and reduce demand on homecare workforces.

For example, one authority used assistive technology to reduce the reliance on formal care visits, with such technologies acting as a prompt and motivator to encourage independent living. Another authority introduced an electronic monitoring system, free of charge to all its homecare providers.

Other evidence of authorities improving the quality of care was seen in work to improve diversity in the care that was available. This included multiple language options or providing support in line with religious needs.

In practice, readers and staff demonstrated they had considered the impact of how their plans and services would impact on people with different protected characteristics. Action had been taken in areas where inequalities had been identified. For example, a specific home care contract was in place with an organisation who delivered care to people in culturally diverse communities.

However, there was little outcome evidence for people included in the reports. And commissioning in some local authorities had not considered diversity, which can lead to inequity.